

EXPERT DECLARATION ALEJANDRA ACUÑA

I, Alejandra Acuña, hereby declare as follows:

1. I am a licensed clinical social worker, accredited by the state of California. I am currently an Assistant Professor in the Department of Social Work at California State University, Northridge.

2. I earned my Ph.D. in Social Welfare from University of California, Los Angeles, in 2015. I also hold a Master's degree in Social Welfare from University of California, Berkeley. I have over 20 years of experience as a clinical social worker and have provided the full range of clinical services, which consists of client engagement, bio-psycho-social-spiritual assessment, diagnosis, treatment planning, clinical interventions and case management, progress monitoring, evaluation, and termination. I have worked with children and families in child protective services systems, non-profit community-based organizations, and public-school districts. Most of my clients have been from low-income, ethnic minority, and/or immigrant communities (including unaccompanied minors), and have experienced domestic and community violence, deportation, incarceration, and other traumatic events. In 2001, I conducted a psychological assessment and provided expert testimony in a deportation proceeding. In the last year, I have completed three psychological assessments for asylum proceedings with three more underway this summer.

3. Attached hereto as Exhibit A is my Curriculum Vitae.

4. My declaration is based on my education, clinical and research experience, as well as a review of scientific literature. Attached as Exhibit B is a list of references to research relied on in support of my declaration.

5. On July 5, 2018, I conducted an evaluation of J. P. at the James A. Musick Facility in Irvine, CA. J.P. is a 37-year-old woman from Guatemala who came to the United States with her adolescent daughter, L.P., in May 2018. I understand from my meeting with J.P., that she was forcibly separated from her daughter by U.S. immigration authorities shortly after arriving in the United States.

1 6. J.P. reports that she was terrified by the fact of separation and thought that
2 she would never see her daughter again. J.P. told me that no one explained to her what
3 was happening. J.P. reports that when her daughter, L.P., was told about the separation,
4 L.P. began to sob, was frightened, fainted, and fell to the ground hitting her face, causing
5 injury with bleeding.

6 7. It is my professional opinion that J.P. is displaying symptoms of post-
7 traumatic stress disorder (PTSD) as a result of her separation from her daughter. J.P.
8 reports having upsetting thoughts or images about being separated from her daughter
9 “almost always.” She reports having bad dreams and nightmares “half the time.” She
10 reports feeling upset when she thinks or hears about events that have transpired “almost
11 always” and reports crying four times a day. She reports having feelings in her body
12 when she thinks about or hears about being separated from her daughter “almost
13 always.” J.P. became visibly tearful when speaking about her daughter. J.P. also
14 reports feeling as if her future plans will not come true “half the time.” She reports
15 having trouble falling or staying asleep “almost always” and waking up three times in
16 the middle of the night. J.P. reports being tired a lot (compared to the energy she had
17 in Guatemala). She also reports having trouble concentrating “almost always.”

18 8. It is also my professional opinion that J.P. is displaying symptoms of both
19 depression and anxiety. J.P. reports feeling nervous, anxious, unable to control
20 worrying, and feeling afraid that something awful will happen nearly every day. She
21 reports that when she sees women leave the detention center, she does not know where
22 they go and what happens to them. She worries what will happen to her next. She also
23 reported feeling down, depressed or hopeless, having trouble falling asleep, and feeling
24 tired or having little energy nearly every day.

25 9. J.P. told me that she wishes she could talk to someone about what is going
26 on and the “sadness she feels in her whole body,” but there is no one at the facility who
27 speaks her language. I have interviewed other women at Musick Detention Center and
28 they have not reported having access to mental health treatment.

1 10. It is my experience that some families who have been detained, have
2 suffered trauma in their countries of origin, as well as on their journey. Where parents
3 and children are already vulnerable, the practice of separating parents from children
4 causes further harm to both parents and children.

5 11. If left untreated, it is my opinion that the symptoms that J.P. has reported
6 could escalate into a diagnosis of PTSD, Dissociative Disorder, and Major Depressive
7 Disorder. PTSD can further escalate into more severe mental health and social
8 problems. According to the fifth edition of the Diagnostic and Statistical Manual of
9 Mental Disorders (APA, 2013), these problems can include (1) intrusive recollections
10 of the event (sensory, emotional, or physiological behavioral components); (2)
11 dissociative states (from a few seconds to several hours or even days); (3) negative
12 alterations in cognitions or mood (begin or worsen after exposure to the traumatic
13 event). Additionally, individuals with PTSD may be quick tempered, engage in
14 aggressive verbal and/or physical behavior, or may engage in reckless or self-
15 destructive behavior. Some individuals experience persistent dissociative symptoms of
16 detachment from their bodies (depersonalization) or the world around them
17 (derealization). Developmental regression, such as a loss of language in young children,
18 may occur. Auditory pseudo-hallucinations and paranoid ideation can also occur.
19 Following prolonged, repeated, and severe traumatic events, individuals may
20 experience difficulties in regulating emotions or maintaining stable interpersonal
21 relationships, or dissociative symptoms. Further, traumatic events increase a person's
22 risk for suicide. PTSD is associated with suicidal ideation and attempts (APA, 2013).
23 There are also functional consequences of PTSD. PTSD is associated with high levels
24 of social, occupational, and physical disability, as well as considerable economic costs
25 and high levels of medical utilization. Impaired functioning is exhibited across social,
26 interpersonal, developmental, educational, physical health, and occupational domains
27 (APA, 2013).
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1 12. It is also my opinion that J.P.'s daughter, who is separated from her mother
2 and currently detained, is at risk of mental health problems as a result of separation. For
3 youth specifically, multiple exposures to stressful conditions puts them at increased risk
4 for developing mental health problems, such as PTSD symptoms (Aisenberg &
5 Herrenkohl, 2008; Lambert, 2010), depression and anxiety (Gopalan, 2010). Similar to
6 other conditions seen in childhood, about 75% of those youth with PTSD have a co-
7 occurring condition such as depression, another anxiety disorder, substance abuse,
8 dissociation, increased suicidal thoughts and behaviors or conduct problems (Aisenberg
9 & Herrenkohl, 2008). Additionally, traumatized children are more likely to be involved
10 in violent relationships, either as victims or perpetrators (Gopalan et al., 2010). Further,
11 ongoing exposure to traumatic events may disrupt cognitive development (Cooley-
12 Strickland et al., 2009), including decreased IQ and be related to decreased academic
13 functioning (Aisenberg & Herrenkohl, 2008) and decreased rates of high school
14 graduation (Stein et al., 2003). Finally, youth need more support than adults because
15 they are less skilled at expressing their trauma-related concerns and have fewer informal
16 and formal sources of support and psychological coping (Cooley-Strickland et al.,
17 2009).

18 13. As a result, I believe that there is a substantial risk of imminent harm for
19 J.P. and any other detainees who remain untreated. Based on my experience, it is my
20 professional opinion that the trauma of family separation places individuals at a high
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1 risk for PTSD or other trauma-based disorders. It is imperative that all parents and
2 children who are similarly situated to J.P. and her daughter be screened for symptoms
3 of trauma, including but not limited to PTSD, depression, and anxiety. Researchers
4 documented various ways that children expressed reactions to their parents leaving,
5 including anger, distress, feelings of vulnerability, abandonment, and somatic
6 complaints (Shapiro et al, 2013). One study found that children separated from their
7 parents due to immigration were more likely to report depressive symptoms than
8 children who had not been separated (Suarez-Orozco, 2002). Another study examining
9 the impact of trauma exposure and immigrant stressors on psychopathology among
10 urban Latino youth found acculturative stress positively associated with
11 psychopathology, separation from either parent associated with externalizing symptoms
12 and PTSD, and lifetime violence exposure strongly related to all forms of
13 psychopathology (Gudino, Nadeem, Kataoka & Lao, 2011). A large, longitudinal study
14 measured three types of separation (not due to death): maternal, paternal, and from both
15 parents, across the ages of 1–15 years (N=985,058). Each type of separation was
16 positively associated with both schizophrenia and bipolar disorder (Paksarian, Eaton,
17 Mortensen, Merikangas & Pederson, 2015).

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19 11. Following screening, any parents or children displaying symptoms of
20 trauma should be provided with immediate treatment. Any delay in providing screening
21 and/or treatment may risk exacerbating the consequences of trauma, and may cause
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1 permanent harm. Children exposed to trauma can experience a number of short-term
2 and long-term disturbances in self-regulation (e.g., avoidance, withdrawal, sleep
3 disturbance, changes in appetite, difficulties regulating mood, and difficulties
4 concentrating, exaggerated startle response, hyper-vigilance, a need to repeat the event
5 through words and/or play, flashbacks or re-experiencing), somatic complaints (e.g.,
6 headaches, stomachaches, and back pain), as well as increased disturbances in mood,
7 developmental achievements, behavior and risk-taking activities (e.g., using drugs and
8 alcohol, promiscuous sexual activity, skipping school, running away from home). If
9 symptoms do not subside over time on their own or with treatment, individuals may
10 develop depression, anxiety, PTSD, personality changes, substance abuse, and impaired
11 school functioning. Additionally, traumatized children are more likely to be involved
12 in violent relationships, either as victims or perpetrators (Gopalan et al., 2010, p. 189).
13 Mexican and Central Americans may be exposed to stress before, during, and after
14 migration (Torres et al., 2018). A growing body of research on the psychosocial impact
15 of forced migration documents the refugee experience as a chronic process of
16 traumatization. The complex cluster of pre-flight and post-flight stressors of war,
17 violent loss, persecution, ethnic conflict, family separation, cultural uprooting,
18 acculturation stressors and legal insecurity forms a pervasive cumulation of life-
19 threatening events and multiple losses and, thus, identifies the refugee experience as a
20 long-term adverse context (Lustig et al., 2004 in Haene, Grietens & Verschueren, 2010).
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1 There is a significant positive relationship between multiple adverse events and poor
2 outcomes; as the number of adverse events increases – even two or more – health and
3 mental health-related outcomes worsen (CAMHII, 2014). Given the number of stressors
4 that families and children face, access to care becomes even more important.

5 12. Appropriate treatment for trauma caused by separation should consist of
6 family therapy, which includes all family members and is necessary to address family
7 pain. Treatment should ideally be provided outside of detention as symptom recurrence
8 and intensification may occur in response to reminders of the original trauma, ongoing
9 life stressors, or newly experienced traumatic events (APA, 2013).

10 13. Attachment theory demonstrates the urgency of providing therapy in the
11 family environment. John Bowlby developed attachment theory by studying the
12 behaviors of normal infants and children who had experienced temporary separations
13 from and reunifications with their parents, in order to make generalizations about their
14 mourning behaviors. Bowlby described attachment as a homeostatic control mechanism
15 that is preferentially responsive to a small number of familial caregivers, maintaining
16 the relationship with the attachment figure within certain limits of distance and
17 accessibility. He asserted that the infant's response to potentially fearful situations was
18 partly dependent on predictions of how available the attachment figures were going to
19 be. He also felt that patterns of attachment became stable over time and could be
20 transmitted intergenerationally. Confusion, helplessness and displaced rage of children
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1 after parent-child separation is a normal reaction (Shapiro et al, 2013). The child must
2 maintain proximity to, contact with, or availability to the significant person because
3 distress will likely be experienced at involuntary separation. To ensure safety and
4 security, close physical proximity to the attachment figure is the set goal of the
5 attachment system for very young children. This attachment behavioral system is
6 important for infants, toddlers, and school-age children in that they are still not
7 competent to make decisions completely on their own regarding their activities,
8 supervision, or protection (Kuehnle & Ellis, 2002).

12 14. A 2001 study demonstrates that parental attachment is critical to recovery
13 from trauma. In a study with children hospitalized for treatment of severe burns, the
14 development of PTSD could be predicted by how safe they felt with their mothers (Saxe,
15 2001). The security of attachment to their mothers predicted the amount of morphine
16 that was required to control their pain – the more secure the attachment, the less
17 painkiller needed. In another study with New York City children who had directly
18 witnessed the terrorist attacks on 9/11, children whose mothers were diagnosed with
19 PTSD or depression during follow-up were six times more likely to have significant
20 emotional problems and eleven times more likely to be hyper-aggressive in response to
21 their experience (Chemtob et al., 2008). While parents need all the help they can get to
22 help raise secure children, traumatized parents, in particular, need help to be attuned to
23 their children's needs. Parents who are preoccupied with their own trauma, such as
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1 domestic abuse or rape may be too emotionally unstable and inconsistent to offer much
2 comfort and protection, which may lead to disorganized attachment. Children with
3 disorganized attachment are at high risk of developing a range of psychiatric problems
4 and show more physiological stress, as expressed in heart rate, stress hormone
5 responses, and lowered immune factors (Hertsgaard et al., 1995). Children whose
6 parents are reliable sources of comfort and strength have a lifetime advantage – a kind
7 of buffer against the worst that fate can hand them (van der Kolk, 2014). So mental
8 health treatment for parents is important for both generations.
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10 15. Some practitioners and researchers have called the Latino family the ‘great
11 untapped resource since it is a natural support system that promotes health,
12 psychological growth and protection against stressors. This is supported by literature
13 that points out many research-based protective factors that prevent development of
14 PTSD after trauma exposure, including parenting, good parental mental health, and
15 good child somatic health history (Qouta, Punamäki & Sarraj, 2008); highly functioning
16 parents and good family relations (e.g., communication, bonding and warmth) (Cooley-
17 Strickland et al., 2009). There is good reason to believe that parents influence the
18 development of behavior in children that may be involved in moderating the impact of
19 stress’ (Masten, 2001).

20 16. Two approaches for the treatment of PTSD treatment among children and
21 adolescents have shown substantial evidence of effectiveness - Cognitive Behavioral
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1 Intervention for Trauma in Schools (CBITS) and Trauma-Focused Cognitive
2 Behavioral Therapy (TF-CBT) - have common elements, including: 1)
3 *Psychoeducation* about PTSD, anxiety, and the prevalence and impact of trauma; 2)
4 *Relaxation and Affective Modulation Skills for* managing physiological and emotional
5 stress; 3) *Exposure or Gradual Desensitization* to memories of the traumatic event and
6 to innocuous reminders of the traumatic event, 4) *Cognitive Restructuring* of inaccurate
7 or maladaptive/unhelpful cognitions, and 5) Parenting, parent-child sessions, and parent
8 sessions. In addition to these common clinical elements, CBT treatment approaches to
9 PTSD also include common delivery components, including and assignment of weekly
10 practice of skills in real-world settings (e.g., home, school), to occur in between
11 sessions. Salient themes that may facilitate resilience: 1) individual coping along with
12 adaptive family functioning; 2) prayer, belief in God, and church services can be
13 adaptive sources of coping; 3) a strong sense of ethnic identity (i.e., a sense of pride in
14 or positive feelings about one's ethnicity and culture; 4) familism, reflecting the values
15 of family solidarity, family support, and an enduring commitment to family members,
16 where one often places the needs of one's family above the individual, has been deemed
17 an important Latino/a cultural value and may buffer the impact of migration-related
18 stressors while family cohesion may be a source of support in the face of immigration
19 stress (Dorsey, Briggs & Woods, 2011).

17. The practice of separating parents from children causes harm to both parents and children, who are already vulnerable from traumatic events before, during, and after their immigration to the US. It is well-established that there is a dose-response relationship between traumatic events and negative physical/mental health outcomes, so it is imperative that further harm is not done and that harm done is addressed. Mental health screening and family-based and effective treatment in a community setting must be provided to parents and children who experienced separation in detention.

I declare under penalty of perjury under the laws of the United States that the foregoing is true and correct.

Executed on July 10, 2018, at Los Angeles, CA.

Alejandra Acuña

Exhibit A

Curriculum Vitae
M. ALEJANDRA ACUÑA, Ph.D. MSW, LCSW, PPSC
aacuna@csun.edu

ACADEMIC APPOINTMENTS

2015- **Assistant Professor**, *California State University, Northridge*; Department of Social Work
2014-15 **Lecturer**, *California State University, Northridge*; Department of Social Work
2014-15 **Lecturer**, *California State University, Los Angeles*; Department of Child and Family Studies,
Department of Chicana/o and Latina/o Studies
2001-14 **Lecturer**, *California State University, Los Angeles*; School of Social Work

EDUCATION, LICENSING & CREDENTIALS

2015 **Ph.D., Social Welfare**, *University of California, Los Angeles*
2007 **Licensed Clinical Social Worker (LCSW)**, *California Board of Behavioral Sciences*
1996 **Master of Social Welfare (MSW)**, *University of California, Berkeley*; Concentration:
Children, Youth & Families
1996 **Pupil Personnel Services Credential (PPSC)**, *California Commission on Teacher
Credentialing*; Specialization: School Social Work; Child Welfare and Attendance
1989 **B.A., Biology**, *Vanguard University*

PEER-REVIEWED PUBLICATION

Acuña, A. & Kataoka, S. (2017). Family Communication Styles and Resilience among Adolescents. *Social Work*, 62(3), 261-9.

IN PRESS

Acuña, M.A., & Martinez, J.I. (in press). Pilot Evaluation of Back to Basics Parenting Training in Urban Schools. *School Social Work Journal*.
Kataoka, S., Vona, P., **Acuna, M.A.**, Jaycox, L., Escudero, P., Rojas, C., Ramirez, E., Langley, A., & Stein, B.D. (in press) Applying a Trauma Informed School Systems Approach: Examples from School Community-Academic Partnerships. *Ethnicity & Disease*.

BOOK CHAPTERS

Acuña, A., Martinez, S., & Warren, B. (1994). Youth and HIV Testing. In M. Quackenbush & K. Clark (Ed.), *The AIDS Challenge: Prevention Education for Young People*. Santa Cruz: ETR Associates.
Acuña, A. (1992). The Smokeless Vision Network. In *Live It Up: Supporting a Tobacco-Free Lifestyle*. NorthBay Health Resources Center.

NON-PEER REVIEWED PUBLICATIONS

Acuña, A. & Escudero, P. (2015). Helping those who come here alone. *Phi Delta Kappan*, 97, 42-45.
Acuña, A. (1996, April). The Child Welfare Worker as Advocate, Part 2. *National Association of Social Workers (NASW) California News*, 22(6), 6.
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Acuña, A. (1995, December). Latin American Immigrants. *FOCUS: A Guide to AIDS Research and Counseling, FOCUS Supplement on HIV Antibody Test Counseling*, 11(1), 1-3.
Acuña, A. (1994, Fall). The Importance of Youth Sensitivity. *FYI: For Youth Information, Newsletter of the Los Angeles County AIDS Programs Adolescent HIV Prevention Project*, 2(2), 3.

SELECTED CONFERENCES & PRESENTATIONS

Minority Male Mentoring: A Multi-Tiered Model for College Success, National Symposium on Student Retention (NSSR), Florida, 2017.

Family Communication Styles, Stressful Events, PTSD and Resilience, Latino Social Worker Organization Conference, Berkeley, 2017.

Evidence-Based Support for Culturally Diverse Students Rising above Trauma: Models for Building Multidisciplinary Workforce, Scaling up Implementation, and Incorporating Youth Voices of Resiliency, The 16th Annual Conference on Advancing School Mental Health, South Carolina, 2011.

Cognitive Behavior Intervention for Trauma in Schools (CBITS), Training for 100 Department of Mental Health sub-contractors, Pasadena, 2010.

Connecting School Social Work Practice to Mental Health and Academic Outcomes, California School Social Work Conference, Oakland, 2008.

The South Los Angeles Resiliency Project: Outcome Evaluation Methods and Results, School Social Work Association of America Conference, Denver, 2008.

Back in Control®: How to get your kids to do what they are supposed to do and Lessons Learned from Developing the School Team Enhancement Project, School Social Work Association of America Conference, Boston, 2006.

HONORS & AWARDS

2009	Friends of School Mental Health Marion McCammond Social Work Award
2004	Heart of Social Work Field Instructor Award - North American Field Educators and Directors
2003	Clinical Instructor appointment, UCLA Department of Social Welfare
2003	Field Instructor, Special Recognition Award, CSULA School of Social Work
2000	Outstanding Field Instructor Award, CSULA School of Social Work
1996	Ryan White's Angel Award for innovative peer education and counseling program, Project ABLE – Los Angeles Free Clinic

SOCIAL WORK PRACTICE EXPERIENCE

2014-	Professional Expert , Los Angeles Unified School District (LAUSD)
2014-16	Clinical Consultant , Plaza Community Services
2013-14	Clinical Supervisor , People Assisting the Homeless (PATH)
2013-14	MSW Intern Supervisor , Glendale Unified School District (GUSD)
2012-13	Clinical Director , El Nido Family Centers
1998-2011	Psychiatric Social Worker (PSW) , Los Angeles Unified School District
1997-98	Neighborhood Outreach Coordinator , Pico Rivera City Hall
1996-97	Social Worker , Sonoma County Family & Children's Services
1993-97	HIV Pre/Post-test Counseling Trainer , State Office of AIDS
1995-96	MSW Intern , Bahia Vista Family Center, San Rafael City Schools
1994-95	MSW Intern , San Francisco Department of Social Services
1992-94	Adolescent Outreach and Education Program Administrator , Los Angeles Free Clinic
1990-92	HIV Services Director , Northeast Valley Health Corporation
1989-90	Health Educator , Northeast Valley Health Corporation

SPECIAL SKILLS

Languages: Fluent in Spanish; conversant in French

Exhibit B

References

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Aisenberg, E., & Herrenkohl, T. (2008). Community violence in context: Risk and resilience in children and families. *Journal of interpersonal violence, 23*(3), 296-315.

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Dorsey, S., Briggs, E. C., & Woods, B. A. (2011). Cognitive Behavioral Treatment for Posttraumatic Stress Disorder in Children and Adolescents. *Child and Adolescent Psychiatric Clinics of North America, 20*(2), 255-269

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Gudino, O.G., Nadeem, E., Kataoka, S.H., & Lau, A.S. (2011). Relative impact of violence exposure and immigrant stressors on Latino youth psychopathology. *Journal of Community Psychology, 39*(3), 316-335.

Kuehnle, Kathryn, & Ellis, Tracy. (2002). The importance of parent-child relationships: What attorneys need to know about the impact of separation; examining the formation of parent-child relationships and how attachment is impacted by parental contact can assist the court in determining the parameters of visitation. *Florida Bar Journal, 76*(9), 67.

Lambert, S.F., Nylund-Gibson, K., Copeland-Linder, N., & Ialongo, N.S. (2010). Patterns of Community Violence Exposure During Adolescence. *Am J Community Psychol, 46*, 289-302.

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Schapiro, N. A., Kools, S. M., Weiss, S. J., & Brindis, C. D. (2013). Separation and reunification: The experiences of adolescents living in transnational families. *Current problems in pediatric and adolescent health care*, 43(3), 48-68.

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Suarez-Orozco, C., Todorovpah, I.G.D., Uiem, J. (2002). Making Up For Lost Time: The Experience of Separation and Reunification Among Immigrant Families. *Family Process*, 41(4),

Torres, S., Santiago, C., Walts, K., & Richards, M. (n.d.). Immigration Policy, Practices, and Procedures: The Impact on the Mental Health of Mexican and Central American Youth and Families. *American Psychologist*, American Psychologist, 2018.

van der Kolk, B. A. (2014). The body keeps the score: Brain, mind, and body in the healing of trauma. New York, NY, US: Viking.